preserved. The condition is never congenital, and heredity in kind plays no part. The pituitary body is hypertrophied, and certain lesions thus find their cause in compression, notably those of the optic nerve, together with various auditory and olfactory disturbances. The microscope reveals only simple hypertrophy of the cell elements of the pituitary body. Treatment thus far is without avail.

L. F. B.

FUNCTIONAL DISORDERS OF THE HEART.

Sir Dyce Buckworth's recent address on this subject is published in the "British Medical Journal" of August 16, 1890. Arrythmia—infrequency, intermittency, irregularity—tachycardia and inordinate vascular pulsation are the disturbances considered. Infrequency occurs in convalescence from acute disease. Increased arterial tension also produces it in less degree. It may be permanent after malarial poisoning. Jaundice causes it, and injuries to the head. Infrequency is met with in encephalitis, meningitis, cerebral abscess, and hæmorrhage; and when physical signs of cardiac disease are detectable, aortic stenosis or fatty condition of the walls may be indicated. There are no facts to justify anxiety or a grave prognosis in respect to longevity on account of infrequent pulse. Intermittency may be unimportant or of the gravest significance. For purposes of diagnosis or prognosis care must be taken to ascertain the degree of arterial tension present. High-tension pulse with intermittency is more serious than the reverse, the condition probably being significant of progressive damage to the valves and coats of the aorta. Intermission after sudden exertion is of graver import than constant intermission. Intermittent pulse usually means some bad habit, as overwork, the use of tobacco, the excessive use of tea or coffee; shock, grief, loss of sleep, anxiety, etc., are recognized causes. The gouty habit may induce intermittency, though it is more apt to bring about irregularity.

Irregularity of rhythm and inequality of tension constitute irregular cardiac action. The pulse is irregular in force and volume. Temporarily this may arise from dyspepsia, emotion, abuse of tea, coffee, etc. Prognosis depends on cardiac textural soundness. In the gouty, irregularity is sometimes very pronounced, persisting for years without the supervention of any detectable organic lesion save weakness. Attacks of overt gout—eczema, phlebitis—may occur from time to time. Transient palpitation is often due to dyspepsia. It exists in connection with chronic rheumatic arthritis and floating kidney. The persistent form denotes profound nervous disorder. Recurrent palpitation in middle life, which may alternate with great infrequency—two hundred beats giving place to thirty-four in a few days—coming on without warning, tend toward a gradual failure of the heart. Inordinate vascular pulsation is found in the abdominal aorta in anæmia, after hæmorrhage due to gastric ulcer, in a tendency to oxaluria, and in hypochondriasis and hysteria. Gout is certainly a cause. Balfour teaches that the nervous origin of palpitation may be ascertained by making the patient exert himself. Extra exertion subdues the rapid action. Were organic lesion present, such as fatty change, the contrary effect would ensue.

L. F. B.

CLINICAL.

A CASE OF APOPLECTIFORM NEURITIS OF THE BRACHIAL PLEXUS, WITH AUTOPSY.

In 1888 Dubois, of Berne, related a new symptom-complex, to which he gave the name "apoplectiform neuritis." Within the last year two other cases were published—one by Déjérine-Klumpke, in Paris, and another by Eichhorst, in Zürich. Quite recently Dubois published his second case.

The symptomatology is the same in all. An individual in apparent health is suddenly attacked by paralysis, accompanied by pain, in the upper extremity. Sensory as well as motor paralysis is complete. Muscular atrophy rapidly develops, and in most cases there exist all of the classic symptoms of electrical reaction of degeneration as one sees in cases of traumatic paralysis. After a long time improvement generally takes place under the influence of electrical treatment. Gradually sensation is restored, but the paralysis and atrophy continue for a longer time, especially in the muscles of the hand.

In the case reported by Déjérine-Klumpke (La Semaine Médicale, 1890, No. 31) the paralysis occurred suddenly, just as the patient attempted to write. It affected the right upper extremity and lasted twenty-two months. The paralysis remained complete for many months, involving not only motility, but also all forms of sensation. Atrophy appeared early, and was soon quite pronounced. When the